



Q&A: The Centers for Disease Control and Prevention (CDC) Recommendations for Lead Poisoning Prevention in Newly Arrived Refugee Children

1) Q: Who was responsible for developing these recommendations, and who else was involved in the process?

A: The CDC Childhood Lead Poisoning Prevention Program (CLPPP) developed and published the recommendation. The office is part of CDC's National Center for Environmental Health. CLPPP also worked closely with the CDC Division of Global Migration and Quarantine, the HHS Office of Global Health Affairs (OGHA), and the Office of Refugee Resettlement (ORR) to ensure that the recommendations were appropriate for the refugee and refugee resettlement communities. The recommendations also have the approval of the American Academy of Pediatrics.

2) Q: The recommendations seem to rely entirely on data from New Hampshire. Yet data from Massachusetts and Minnesota were quite different, and did not show evidence of substantial increases in blood lead levels pre- and post- arrival. Did CDC look at other data?

A: The recent report in the MMWR (Elevated Blood Lead Levels in Refugee Children New Hampshire, 2003-2004) focused on the experience of refugee children in Manchester New Hampshire. At the time Manchester was one of the few places in the country where refugee children were required to be tested for lead both on arrival and subsequent to permanent placement. This made it possible to identify a pattern that may have been missed in other places where the combination of poorly maintained old housing, poor nutrition and lack of understanding of the dangers of lead put refugee children at exceptional risk for lead exposure. In Massachusetts we also found in a group of 660 refugee children from Europe, Asia, Africa and the Americas, were more likely to have elevated blood lead levels 6 months after resettlement than were U. S. born children (Geltman P, Brown MJ, Cochran J. Lead poisoning among refugee children resettled in Massachusetts, 1995 to 1999. Pediatrics 2001;108:158-162.) Given these data it seems prudent to test children 3-6 months after they are resettled.

3) Q: Why has the recommended age of Blood Lead Level (BLL) testing increased to 16 years of age?

A: CDC, in consultation with the American Academy of Pediatrics (AAP) decided to increase the age range for BLL testing. Although children 6 years old and younger remain at the highest risk for elevated lead levels and lead poisoning, age does not predict risk for lead exposure in refugee populations who are relocated from areas with high ambient contamination. Therefore all children 16 years and younger should be given at least an initial test for an elevated BLL. Refugee children should be tested for lead on arrival until at least 16 years of age because they may be exposed to lead in the country of origin or to lead in products they brought with them or purchase in import stores.

4) Q: Why is it recommended that only refugee children that are age 6 years and younger be repeat tested for elevated BLL, 3-6 months after being placed in residences?

A: Most state and local lead poisoning prevention programs recommend screening for children less than 6 years old because; 1) young children are more at risk for exposure because their normal hand to mouth activities puts them in contact with lead dust and soil, 2) they have higher absorption rates than older individuals and 3) they are more sensitive to the adverse health effects of lead. However, in the Geltman article cited above we did not find that age was a predictive of elevated blood lead levels in refugee children. Thus we recommend repeat testing for children less than 6 years old or older children if local conditions indicate. This means that if public health or clinical health providers determine that older children in their care are at risk for lead exposure, these children should be tested as well.

5) Q: Why are younger refugee children at risk of developing elevated BLL, if they have been placed in environmentally safe housing?

A: Refugee children suffer a higher incidence of malnutrition and anemia, than can be found in their corresponding U.S.-born age group. Malnutrition and anemia facilitate the quick absorption of trace amounts of lead into the bloodstream, and can therefore lead to harmful BLL in smaller children. Refugee children not only absorb lead through contact with internal surfaces in their housing units, but also through soil and external play spaces as well. In addition, because their parents and caregivers are not knowledgeable about lead exposure and how to prevent it, the children may engage in behaviors, such as eating soil, that place them at increased risk.

6) Q: When should the recommended nutritional evaluation and corresponding blood tests be done? Who should be responsible for administering these tests?

A: The blood tests should be performed when refugee children undergo their initial refugee health assessment. The state or local health care provider and corresponding state government official in charge of refugee health assessments are responsible for making sure that these tests are conducted.

7) Q: If a refugee child is identified as anemic or malnourished, who should supplement and monitor their nutritional and iron intake therapies?

A: The child's primary health care provider should discuss daily vitamins with the family and if necessary write a prescription for them. The state or local health care providers and state government official should partner with the appropriate resettlement agency or affiliate to ensure that the parents or caretakers of malnourished refugee children receive nutritional education. Iron supplements should be provided by the local health care provider. OGHA and ORR will partner with CDC to provide a nutritional training workshop for resettlement agencies. The nutritional well-being of refugee children is an issue that extends beyond lead. Most if not all of these children qualify for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

8) Q: Who should pay for these lead and nutritional tests, therapies and treatment regimens?

A: CDC has consulted with the Centers for Medicare and Medicaid Services (CMS), and all these tests and treatments should be covered under either standard Medicaid, State Child Health Insurance Programs (SCHIP) or Early and Periodic Screening, Diagnostic and Treatment (EPSDT). This is true, regardless of how limited the state's Medicaid plan might be. Refugees who fulfill the Medicaid requirements of a 'covered group' i.e. low income children are mandatory qualified aliens. As such they are eligible for Medicaid and the Early

Periodic Screening Diagnosis and Testing program (EPSDT) and state Medicaid agencies MUST provide blood lead screening and other medically necessary tests. If you are told that these services are not covered under Medicaid, please contact a CDC, OGHA or ORR team member and notify them. (Contact information provided below.)

9) Q: CDC does not provide specific recommendations for environmental and housing are they planning to address this in another form?

10) Q: How would a case worker know if a home may contain lead hazards?

A: (Answer relevant for Q 9 and 10) CDC is working with several organizations to develop a training toolkit to help resettlement workers and other social service providers who work with refugee families educate them on the hazards of lead exposure. The toolkit will include an easy assessment survey that can help alert the resettlement workers to high lead hazard environments.

11) Q: What are the laws that state what the standards are for housing and lead? Does this vary from state to state?

Yes the laws vary from state to state and some states do not have laws that address residential lead paint. State laws and regulations can be found on the CDC Lead Poisoning Prevention branch website at <http://www.cdc.gov/nceh/lead/lead.htm>

12) Q: Who is responsible if a house poisons a refugee child?

Some states have laws or regulations that require that housing with young children, refugee or not, be maintained in a lead-safe manner. These laws may also assign responsibility, usually to the property owner if housing is not lead-safe. State laws and regulations related to childhood lead poisoning prevention can be found at <http://www.cdc.gov/nceh/lead/lead.htm>

13) Q: Who should I contact if I have more questions?

A: Please contact either:

Connie Thomas, CLPPP, CDC, (770) 488-3631 cbthomas@cdc.gov

Arjun Prasad, OGHA, (301) 443-7243 aprasad@osophs.dhhs.gov

Marta Brenden, ORR, (202) 253-3589 mbrenden@acf.hhs.gov
